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HOW TO MEASURE THE EFFICIENCY OF LOCAL HEALTH OFFICERS.[1]

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The value of a person to society is largely measured by his ability to discharge efficiently his professional obligations. For instance, the chief of a police department is evaluated by his ability not only to bring lawbreakers to the bar of justice but also to prevent crime. Some of the most successful guardians of the law seldom make an arrest, but gain their ends through educational efforts which serve to prevent wrongdoing. Somewhat similarly the worth of a fire chief is judged by his ability to prevent conflagrations as well as to extinguish as speedily as possible those which do occur.

The local health officer is likewise judged by the results attained, not alone in combating promptly, courageously, and effectively the disease epidemics which arise, but more particularly in preventing such outbreaks. In measuring the effects of health administration difficulty is encountered; for it appears to be much simpler to tally the cases of sickness and death than to determine the number of persons who were spared such affliction. This difficulty is particularly obvious in the campaign against venereal diseases. Actual reported cases of venereal diseases are tangible. However, there is no way at present of knowing how many persons are deterred through educational effort from acquiring venereal diseases. Until a practical system of measuring these efforts can be devised, the full effect of this work will neither be adequately appreciated nor whole-heartedly supported.

What has been said of one vital branch of public health administration, namely, venereal disease control, applies with equal emphasis to the general problem. However, if genuine progress is to be made in public health work, some method, even though productive of only approximately satisfactory results, must be devised for gauging the results achieved by local health officers. Such a system of appraisement is as necessary to an efficient civic administration as a system of financial accounting. The community employing the health officer has a definite right to know whether he is accomplishing results. Even more important, a system of self-examination enables the health officer himself to ascertain what beneficial results to the com-

[1] Read before the Fifth Biennial Conference of Local Health Officers, Madison, Wis., Sept. 29, 1920.

munity accompany his efforts. A consideration of the local health officer problem in Wisconsin affords ample justification for suggesting a system of efficiency evaluation.

There are at present in the State of Wisconsin 1,740 cities, villages, and townships for which local health officers are legally required. One hundred and forty-three, or 8.2 per cent, of the aggregate are cities; 320, or 18.4 per cent, are villages; and 1,277, or 73.4 per cent, are townships. It will be noted that nearly three-fourths of the localities having health officers are essentially rural in character, whereas the remaining one-fourth are urban in character. This analysis clearly indicates the especial desirability of improving and strengthening health administration in rural districts.

A further examination of the health officer situation in Wisconsin shows that 1,695, or 97.4 per cent, of the 1,740 health jurisdictions have organized boards of health and designated health officers, leaving only 45, or 2.6 per cent, of the entire number without legal health machinery. As steady pressure continues to be exerted upon the delinquent localities, it is believed that a 100 per cent State health organization will soon be a reality. In presenting these figures it is realized that many local health organizations exist on paper only, and that in so far as activities are concerned, a veil should be charitably drawn. However, even so inadequate a condition marks a distinct advance.

A still further analysis of the personnel occupying the 1,695 local health officerships shows that 892, or 52.6 per cent, are physicians, while 803, or 47.4 per cent, are laymen. Four of the physicians and three of the lay health officers are women. Any system of education in health administration or appraisal of health effort in Wisconsin must therefore take into consideration the fact that approximately one-half of the officials are laymen. Further allowance must be made for the fact that but 9, or only 0.5 per cent, are whole-time officials, whereas 99.5 per cent, or 1,686, serve only part of the time.

Briefly and broadly stated, it is the business of the health officer to administer the affairs of his office so that the human beings in his jurisdiction may live comfortably and happily, harassed as little as possible by unnecessary sickness and suffering, and likewise spared premature death. That only an approximate degree of perfection in this respect can be obtained, is obvious. Nevertheless, it should constitute the ideal which every health officer with a conscience should strive to attain. When a health officer does nothing, the people in the community erroneously jump to the conclusion that there is nothing to be done. Consequently, nothing is done. In the presence of such an attitude, unnecessary sickness and death are inevitable.

It is unfortunate that health officers are invariably underpaid. This glaring inadequacy is one which must soon be studied intensively, and efforts must be put forth for the correction of the existing evils. However, mere inadequacy of salary can not be offered as an excuse to condone the failure to afford reasonable health protection. The conservation of human life, especially child life, is a trust too sacred to be subordinated to quibbling over salary matters. Once a person has accepted the position of local health officer or taken the oath of office, he is in honor bound to give the best service of which he is capable. If he considers himself worth $500 or $5,000 a year, but receives but $50 a year, he can not either in justice to the people or in common decency afford to compromise on $50 worth of service.

How, then, can we estimate the value of local health officers and at the same time provide a mirror in which these officials may see themselves and, viewing themselves, judge of the adequacy of their efforts? Most simple of measuring devices is the score card, familiar to everyone through its application to the determination of sanitary conditions in dairies, dairy farms, restaurants, and the like. It is believed that the ordinary score card, with some modifications, will prove particularly useful as a means of measuring the efficiency of local health officers. Moreover, it is believed that the scoring of these officials in the manner indicated will result in an awakening which will immediately be reflected in an improvement of the public health.

The standard scoring form comsists of two headings, (1) Methods, and (2) Equipment, beneath which are considered the various factors entering into the appraisal of the subject under consideration. Adjoining columns are provided for perfect and allowed scores. Attention is directed to the fact that in the score card for the health officer the activities are arranged in order of importance; those judged to be most essential are allowed the highest scores, while the lowest are considered least important and therefore are allotted the smallest scores. No comment will be made as to the relative merits of the items listed, for these are generally appreciated and understood.[2] Incidentally, however, the bearing of several of the listed health activities upon the general administrative plan will be amplified in an attempt to justify their inclusion.

[2] EDITORIAL NOTE.—The relative weights given in the accompanying forms are the author's own figures. They will, no doubt, allow of some revision, but they furnish a point of departure at least.

SCORE CARD—FOR SCORING THE EFFICIENCY OF LOCAL HEALTH OFFICERS.

1. ACTIVITIES.

Character of activity.	Score in points.	
	Perfect.	Allowed.
1. Communicable diseases: Suppression and prevention	18	
2. Laboratory diagnosis: Collection and transmission of specimens for diagnosis and investigation. Distribution of antitoxins and serums	10	
3. Education of public: Exhibits, lectures, circulars, newspaper articles, etc	8	
4. Vital statistics	7	
5. Coordination of extraneous health agencies	6	
6. Concurrent disinfection	6	
7. Infant and maternal welfare work	6	
8. Public health nursing	5	
9. Control of water supplies	4	
10. Inspection and control of milk supplies and dairies	4	
11. Occupational disease: Prevention and control	4	
12. Medical inspection of school children and correction of defects	4	
13. Mental hygiene	3	
14. Control of such preventable diseases as heart and kidney diseases, etc	3	
15. Clerical work: Correspondence, records, and reports	3	
16. Sewage disposal	3	
17. Attendance at conferences, board of health meetings, etc	3	
18. Food and meat inspections and control of slaughter houses, butcher shops, and grocery stores	1	
19. Inspection of public buildings	1	
20. Terminal fumigation	½	
21. Investigation and abatement of nuisances	½	
Total	100	

SCORE CARD FOR SCORING THE EFFICIENCY OF LOCAL HEALTH OFFICERS.

2. EQUIPMENT.

Nature of equipment.	Score in points.	
	Perfect.	Allowed.
1. Telephone	20	
2. Transportation	17	
3. Clerk	12	
4. Office	10	
5. Report cards:		
a. From physicians	5	
b. To State board of health	5	
6. Quarantine placards	8	
7. Vaccine and antitoxins or facilities for obtaining same	7	
8. Record books or filing cases	6	
9. Literature for self-education and reference	5	
10. Literature for distribution	4	
11. Fumigants or facilities for obtaining same	1	
Total	100	

Many health officers, particularly the part-time officials and those without medical training, may view this score card with apprehension. There may be a feeling that such a system of efficiency meas-

urement is intended solely for large, whole time, well organized, and properly financed departments. Yet, brief consideration of the matter will suggest possibilities for even the smallest town health department. Much of the success in public health administration results from the ability of the health officer properly to coordinate existing extraneous agencies and so direct their energies that a harmonious result is obtained.

A recent census has shown that there are 130 national organizations directing their attention to branches of public health work. In the Federal Government alone there are 33 departments performing public health work of some character or another. States and even cities are likewise fields for numerous organizations which operate independently. One of the health officer's most important functions is the coordination of all scattered activities in his locality, together with the centralization of the authority. If this practice were more generally followed, more successful work could be performed by fewer workers and at greatly decreased cost to the people who pay the taxes or make the contributions. It appears not to be generally understood that governmental and voluntary agencies covering every conceivable field of public health endeavor are willing and even anxious to assist health officers in solving local problems. Needless to say, governmental agencies, be they Federal, State, or municipal, are logically the ones to assume the leadership in health matters.

The truly successful health officer is one who has sufficient intelligence and foresight to call for assistance when it is needed, and, having obtained such assistance, capitalizes the results to his own credit. Therefore, even a town health officer can obtain a reasonably high score if he will devote some study to the needs of his community and freely use the numerous health agencies at his command.

The suggested score card accomplishes two important functions: (1) It stimulates the health officer to increased activity, points out the relative importance of the various branches of public health administration, and provides a means of self-measurement; (2) it provides the State board of health and the local community with a means of estimating the values of the official. Despite these obvious advantages, there is a serious defect in the score card, namely, the failure to provide a means for measuring accurately the results of the health officers' activities. While it is reasonable to suppose that energetic public health endeavor will prevent much unnecessary sickness and premature death, actual measurements must be employed in order to prove the contention.

While considerable skill is required in arriving at accurate statistical conclusions, nevertheless in small communities helpful calculations can be made by comparing present day disease conditions with those experienced in preceding years, making reasonable allowances

for changes of population. However, no local health officer should be satisfied merely to excel previous conditions in his own jurisdiction; he should not be content until he has surpassed the best records in his State and even in the country. The constant aim should be to prevent disease, thereby lessening human suffering and preventing death. By examining the frequent reports of the division of vital statistics of the State board of health, standards for statistical study will be constantly available. Certain it is that health work can not be carried on intelligently without a careful, regular, and intelligent checking up. Whether this is accomplished by simple comparison or by lengthy mathematical calculation, it nevertheless should be done.

Definite results usually follow definite action. When they do not, one of two things is possible: Either the efforts are misdirected and inadequate or peculiar circumstances exist, necessitating a change of tactics. In any event the proof of any health officer's efficiency is his ability to keep the morbidity and mortality rates perceptibly lower in his locality than they are elsewhere.

This can be done most successfully by obtaining a proper public health perspective and concentrating upon the phases of the problem which experience has shown to be necessary in securing the maximum protection against disease.

INTERNATIONAL SANITARY CONVENTION.

PROCÈS VERBAL OF THE DEPOSIT OF THE RATIFICATIONS BY THE UNITED STATES AND OTHER GOVERNMENTS, OCTOBER 7, 1920, OF THE INTERNATIONAL SANITARY CONVENTION SIGNED AT PARIS JANUARY 17, 1912.

International conferences, having for their purpose the formulation of international sanitary regulations, were held in 1892, 1893, and 1894; the Convention of Venice was signed in 1897, and Conventions of Paris were signed in 1903 and 1912.

The general provisions of the International Sanitary Convention of Paris of 1903 prescribed the action to be taken by the countries signing the convention on the appearance of plague or cholera in their territory. The convention contained the following provisions: The notification to the other Governments by each signatory power, of the first appearance of recognized cases of plague or cholera in its territory; the publication by each country of the measures prescribed; the disinfection of merchandise; and measures to be enforced at ports and land frontiers.

The last International Sanitary Convention was signed in Paris on January 17, 1912. This convention made such modifications in the provisions of the Paris Convention of 1903 as were warranted by the new data of prophylactic science and experience; enacted new international regulations in regard to yellow fever; and extended as far as possible the field of application of the principles underlying the